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ANNUAL REPORT OF THE COMMUNITY MENTAL HEALTH PROMOTION PROGRAM

1995/1996 -

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REGION OF HAMILTON-WENTWORTH

- RECOMMENDATION -

DATE: 1996 July 26

REPORT TO: Chairman and Members
Health and Social Services Committee

FROM: Dr. Marilyn James
Medical Officer of Health

SUBJECT: **Community Mental Health Promotion Program (HEA 96-115)**
- **1995/96 Annual Report**
- **1995/96 Operational Plan**
- **1995/96 Operating Budget, Financial Summary**

RECOMMENDATION:

a) That the Medical Officer of Health be authorized and directed to forward copies of the 1995/1996 Community Mental Health Promotion Program Annual Report (Appendix I), 1996/1997 Operational Plan (Appendix II) and the 1996/1997 Operating Budget Financial Summary (Appendix III) to the Mental Health Program Consultant, Mental Health Program and Services Branch, Ministry of Health.

b) That copies of the 1995/1996 Community Mental Health Promotion Program Annual Report be sent to the Community Mental Health Promotion Program Community Advisory Board, District Health Council and interested community agencies.

Marilyn L. James
Medical Officer of Health

FINANCIAL/STAFFING/LEGAL IMPLICATIONS:

- The program is 100% funded by the Ontario Ministry of Health.

- The staff allocation is:
  .75 full time equivalent (fte) Program Manager
  3.0 fte Public Health Nurses
  0.5 fte support staff.

- The 2% budget reduction ($5,560) required by the Ministry (Appendix IV) for 1995-96 was achieved through reduction of operating and rent expense.

- The 1996-97 proposed 3% reduction will require a change in staff mix which will impede our ability to serve the most seriously mentally ill people in our community.

SUSTAINABLE DEVELOPMENT IMPLICATIONS:

(Vision 2020, adopted by Regional Council as their vision for the future of Hamilton-Wentworth, embodies the concept of a sustainable community which is an equal balance of the economy, the environment, and social/health factors in all regional decision-making)

This report describes services that directly address health/social factors of individuals surviving serious mental illness. The impact of reducing episodes of poor coping results in less economic cost to the community.

BACKGROUND:

The fiscal year 1995/1996 represents the tenth year of operation for the Community Mental Health Promotion Program (CMHPP). The CMHPP provides case management and counselling/treatment services to people with severe mental illness or those at risk for mental illness. The primary purpose of the program is to enable these individuals to achieve their optimal health.

Prepared by: Ruth Schofield
Program Manager
Community Mental Health Promotion Program

1995/1996 ANNUAL REPORT

COMMUNITY MENTAL HEALTH PROMOTION PROGRAM

25 MAIN STREET WEST, 5th FLOOR

HAMILTON, ONTARIO

L8P 1H1

HAMILTON-WENTWORTH REGIONAL PUBLIC HEALTH DEPARTMENT

FUNDED BY: THE MINISTRY OF HEALTH

MENTAL HEALTH PROGRAM AND SERVICE BRANCH

COMMUNITY MENTAL HEALTH PROMOTION PROGRAM

CMHPP STAFF

Kathy Ferguson
Mishi Ide
Barbara Overby
Darlene Power
Ruth Schofield
Linda Veenhuis (HPH staff)
Lee Anne Weibe

Community Advisory Board

Mike McDonagh, Chairperson
Helen Kirkpatrick, Acting Chairperson
Doug Bailey
Geraldine Copps
Patricia Gains
Erin Gallacher
Susan Graham
John Iovio
Darlene Power
Donna Rosizky
Jim Rothwell
Yolanda Rutka
Ruth Schofield
Matthew Sircelj
Jane Underwood

CHAIRPERSON'S REPORT

In the past year, the major accomplishments were the commencing of the Community Outreach Project and the successful completion of Bridge to Discharge Pilot Project The Community Outreach Project works with primarily women with serious mental illness who are homeless.

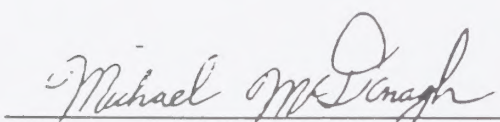
The Community Advisory Board was involved with a number of activities. These activities include:

- identifying issues related to banking services for people on social assistance
- planning a client survey
- learning about Bill 26 and Bill 19's effect on client care
- advising on the operational plan
- submitting a Community Investment Fund proposal for case management services with people who have serious mental illness and are homeless
- meeting with Roomers and Boarders Committee members about the need for outreach services to people in rooming houses
- supporting the program's involvement with forensic services for people with mental illness and
- sharing information about new services

I would like to acknowledge Bob Bradshaw, past acting chairperson, Linda Maude and Colleen McDonald for their dedication and contributions on the Community Advisory Board over their term on the Board. I would also like to welcome the following new members, Susan Graham and Donna Rosizky.

I am grateful as a consumer to be a voice for consumers. I would like to ask the Ministry of Health for renewed empathy for the consumers who are not able to speak up due to mental illness.

I would like to thank the members of the Community Advisory Board for their shared insights and to thank the staff of the Community Mental Health Promotion Program. Sincere and grateful thanks to Ruth Schofield, Program Manager and Jane Underwood, Director of Public Health Department, Nursing Services. Together, we can work to make effective nursing a mastered reality and consumer self-actualization a by-product in this exciting age of patient care.



Mike McDonagh, Chairperson
Community Advisory Board

EXECUTIVE SUMMARY

The Community Mental Health Promotion Program with the Hamilton-Wentworth Regional Public Health Department provided community based case management services for people with serious mental illness. In the past year, 122 people were involved with the program. There were 32 admissions and 20 discharges. The majority of the clients served were females between 35-64 years of age. The majority of the clients (42%) lived in independent supported housing. The majority of the people (89%) in the program had a major psychiatric disability of either schizophrenia or an affective disorder. The remaining people (11%) had other mental illnesses.

Consumer objectives included establishing an open, comfortable and supportive relationship with the nurse, developing skills important for living, not getting sick and being hospitalized and socializing with others as one chooses. At the end of the year or upon discharge, 65% of the clients demonstrated that a relationship was being established beyond the initial phase. Clients in the CMHPP demonstrated an improvement in 64% of their community living skills. Hospitalization patterns reviewed on clients for more than 18 months revealed that 67% clients demonstrated a decrease in their hospitalization pattern. In terms of social supports, it was found that 8% of the clients had no contacts beyond the nurse; 50% of the clients had some other person to confide in; 34% of the clients participate in social and recreational activities; and 8% had both a person to confide in and involvement with recreational activities. Over the year there were 6% more clients participating in social recreational activities.

The Bridge to Discharge Project in collaboration with the Mental Health Rights Coalition and Hamilton Psychiatric Hospital, provided support to long term hospitalized clients as they move into the community. The two year evaluation revealed client satisfaction, improved quality of life such as a greater sense of autonomy and control, and a cost savings of $496,862.55. Up to five clients lived independently in supported housing and up to 25 inpatients and 12 community clients regularly utilized the teaching apartment.

The Community Outreach Project in partnership with the Hamilton Psychiatric Hospital demonstrated that working relationships with people with mental illness who are known to be "hard to reach" can be established. Due to the disenfranchised nature and significant functional disability of this population, it was premature to determine the impact on their quality of life. The integration of community and hospital staff revealed a very promising partnership.

The program consulted with SLLH operators and public health nurses in the nursing programs and facilitated educational activities for SLLH operators. Community linkage activities included professional education with Garwood Jones Lectureship Planning and client education through the sexuality health promotion group with Hamilton Program for Schizophrenia. Program staff also participated in regional mental health service planning with Regional Psychiatric Program and Hamilton-Wentworth District Health Council Mental Health Reform Steering Committee.

Through the affiliation with the Teaching Health Unit, nursing students had a learning opportunity in community mental health. In the past year research activities included Bridge to Discharge Project and the Community Outreach Project. Program staff provided a number of presentations on research findings.

INTRODUCTION

The fiscal year 1995/1996 represents the eleventh year of operation for the Community Mental Health Promotion Program (CMHPP), providing a unique blend of public health and mental health services within our community. Funding is provided by the Ministry of Health, Mental Health Programs and Services Branch. Administration is through the Hamilton-Wentworth Regional Public Health Department (RPHD).

In the best tradition of public health and community outreach, the CMHPP's direct service activities are carried out in the individuals' own place. People involved with the program are offered either short term counselling/treatment services or long term case management services. The primary purpose is to enable people with severe mental illness to achieve optimal health. The following report describes the results of the consumer and program objectives from the 1995/1996 operational plan.

POPULATION PROFILE

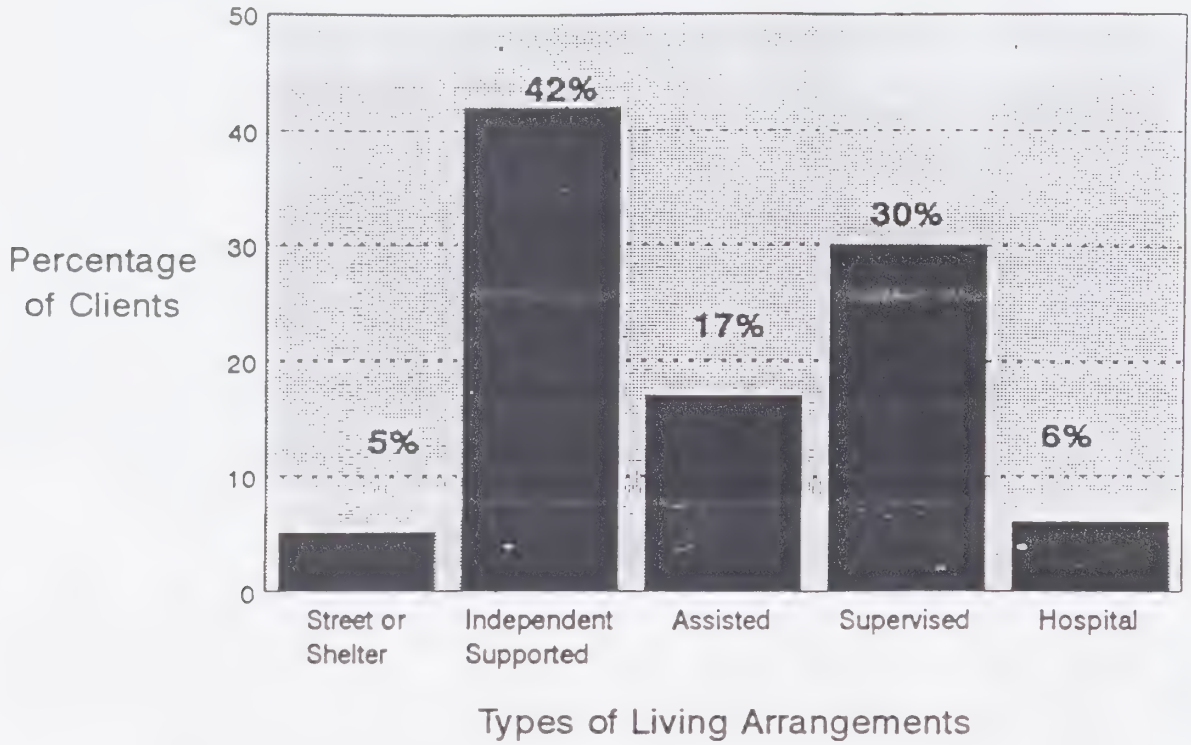
The CMHPP staff were involved with 122 people with severe mental illness or complex mental health problems. Of the 122 people, 9 individuals participated in a sexual health promotion group and 14 people were involved with the Community Outreach Project (COP). Of the 113 receiving the one to one service, 81 participated in the case management service and 32 participated in the counselling/treatment service. During 1995/96, 32 people compared to 33 in 1994/95, joined the program. Nine more clients were accepted; however, upon admission were found to be involved with another service and therefore were not followed. Twenty people left CMHPP. On average, people who were involved with the counselling/treatment service participated for about six months. In comparison, the individuals receiving the case management services, on average, participated for about 3.9 years. Of the 81 people receiving case management, 61 (75%) were between 35-64 years of age (Table 1). Of the 32 people involved with the counselling/treatment services, the largest sub-group of people were between 35 to 54 years of age (71%) (Table 1). Forty-five percent of the people participating in the program were single. Sixty three percent were female (Table 1). The majority of the people (89%) in the program had a major psychiatric disability of either schizophrenia or affective disorder (Table 1). The largest sub-group of people resided in independent supported living arrangements (42%) followed by supervised environments such as Second Level Lodging Home (30%) (Figure 1). The average number of residences in one year for clients involved in the Community Outreach Project was 4.3 which indicates the housing instability of this population.

TABLE 1: Comparison of Age, Marital Status, Sex and Diagnosis of Clients Receiving Case Management and Counselling/Treatment Services (n=113)

	Case Management	Counselling/Treatment
Age:		
16-24	1	1
25-34	10	3
35-64	61	23
65-74	7	4
75+	2	1
Total	81	32
Marital Status:		
Single	37	14
Married	10	5
Divorced	19	6
Widowed	7	5
Separated	8	1
Total	81	32
Sex:		
Male	29	12
Female	52	20
Total	81	32
Diagnosis:		
Affective Disorders	20	8
Schizophrenia	49	24
Other *	10	
Unknown	2	
Total	81	32

* Other diagnosis include personality disorder, acquired brain injury.

FIGURE 1: The Percentage of Clients Residing in Different Living Arrangements in the CMHPP.



CASE MANAGEMENT

The CMHPP worked with people who have a severe mental illness integrating principles of psychosocial rehabilitation through a case management model. Trusting relationships were established with the people through which goals could be identified and acted upon. The client and the nurse collaboratively worked to achieve these goals.

COUNSELLING/TREATMENT

Individuals involved with the counselling/treatment services generally experienced complex mental health problems or serious mental illness. Similar to the individuals involved with the case management services, these people are referred to the CMHPP by hospitals, doctors, lodging home operators, community agencies and other public health nurses. The average amount of time per client in each quarter was 8.5 hours with an average of one hour per contact. On average the nurses' time was primarily direct service with clients (65%) which consists of one-to-one contact in the clients' place of residence, conferences, consultations and group activities.

In comparing the Ministry of Health benchmarks and target for case management services, the CMHPP provided elements of both intensive case management and generic case management services depending on the clients' needs and partnerships eg. Bridge to Discharge Project (Figure 2).

FIGURE 2: Comparison Between the Community Mental Health Promotion Program (CMHPP) and the Ministry of Health Benchmarks and Targets for Case Management services

Comparison of Elements between Intensive and Generic Case Management Services and the CMHPP

Intensive Case Management	Community Mental Health Promotion Program	Generic Case Management
Caseload 15-20 or fewer	1:24 1:11(COP)	Caseload avg.< than 40
>50% of contact outside of office	100% outside the office	20% of contact outside of office
>20% of consumers are seen >than 1x/week	CMHPP: 28% are seen > than 1x/week COP: 91% are seen > than 1x/week	no limits on the # of contacts or length of time in program
available more than weekday basis	• evenings as needed • Bridge to Discharge Project provides 24 hours/day, 7 days/week services	
proactive outreach	yes	

Common Elements of Both Intensive and Generic Case Management

Common Elements	CMHPP
100% of clients have serious mental illness	89%
Functions of Case Management	
a) individualized assessments	yes
b) service coordination	yes
c) monitoring and evaluation	yes
d) system advocacy/resource development	yes

CONSUMER OUTCOMES

CONSUMER OBJECTIVES

Through survey and focus groups the clients made their objectives known to the program staff.

a) to have an open, comfortable and supportive relationship with a nurse
b) to develop and/or improve skills important for living
c) to not "get sick" and be hospitalized
d) to do social, recreational and educational activities in the community with others as one chooses

A, HAVING AN OPEN, TRUSTING AND COMFORTABLE RELATIONSHIP WITH THE NURSE

The client and nurse saw each other on a regular basis which enabled the client and nurse to establish a trusting relationship. The client/nurse relationship was assessed based on Peplau's theory and plotted on a modified client outcome form (Appendix A). Within this model, clients usually started at the orientation phase and, over time, progress through the four key phases. All charts were audited to evaluate the phases in the client/nurse relationship. Progress of clients through the phases was summarized on Table 2. This table described all clients involved in a one-to-one relationship with a nurse during 1995/1996. The greatest clustering on admission to the CMHPP was at Orientation Phase. At March 31, 1996 or on discharge from the CMHPP the greatest number of clients were at the Identification and Exploitation phases. At the end of the year or upon discharge 65% of the clients demonstrated that a relationship was being established beyond the Orientation Phase.

Table 2: Phases of the Nurse/Client Relationship

Phase of Relationship	Admission	March 31,96 or on discharge
Orientation	84	25 (39)*
Identification	21	42
Exploitation	8	31
Resolution	0	1
TOTAL	113	113

* The discrepancy in the numbers is related to the people involved with the Community Outreach Project

B) COMMUNITY LIVING SKILLS EVALUATION

Through the record review of client outcome form, a modified St. Louis Inventory of Community Living Skills (an evaluation of the clients' community living skills) was utilized (Appendix 1). Community living skills assessed included: self-care, safety, clothing maintenance, meal preparation, handling of time, handling of money, health practices, communication, problem solving, use of resources and leisure activities. Each skill was assessed on a scale ranging from few or no skills to self-sufficient and very adequate skills. This evaluation enabled the nurse and client to determine the clients' community living skills and the amount of help needed when they begin the program and on a yearly basis. As a result, the client was assisted to achieve their goals to develop or maintain these skills necessary to stay in the community.

On admission, the findings were that the average rating of the clients in the CMHPP was between needs moderate help to has moderate skills (Figure 3). The clients' strongest skills identified were safety, self care and use of resources. In comparison, on admission clients in the Community Outreach Project (COP) were found to have fewer skills and consequently would require moderate help (Figure 3). Their strongest skills were use of resources and safety. Twelve percent of the clients volunteered. On March 31, 1996 clients in the CMHPP demonstrated an improvement in seven of the eleven (64%) community living skills (Figure 4). The most significant improvement was in the area of use of resources which could indicate clients becoming more integrated into the community. It was too early to determine any significant change in the community living skills of clients in the Community Outreach Project. Since admission to the project, forty one percent of the clients demonstrated an increased length of stay in one environment.

C) HOSPITALIZATION

The record review analyzed the hospitalization pattern of clients involved with the program for greater than 18 months. Not all clients' results could be analyzed. For example, if a client's pattern was a hospitalization every two or three years, after 18 months of care without hospitalization, it would be too early to determine a change in pattern. There were 45 clients that had been in the program for minimum of 18 months and were able to be assessed for their hospitalization patterns. Of the 45 clients, 30 (67%) clients decreased their hospitalization pattern, 6 (13%) had no change in hospitalization patterns, 2 (4%) had an increase in hospitalization, 3 (7%) the history was unknown due to lack of client permission, 3 (7%) had only one admission to date and 1 (2%) had no hospitalizations.

FIGURE 3: Comparison of Community Living Skills Between Clients in the Community Outreach Project & CMHPP on Admission

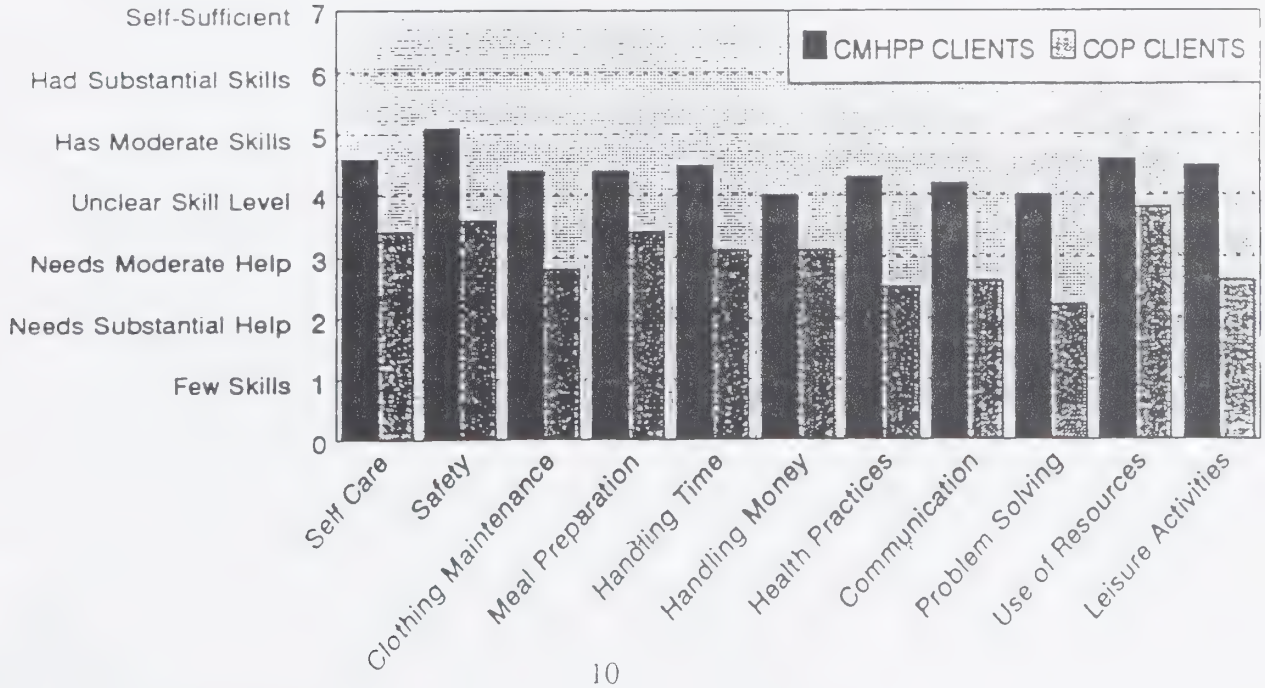
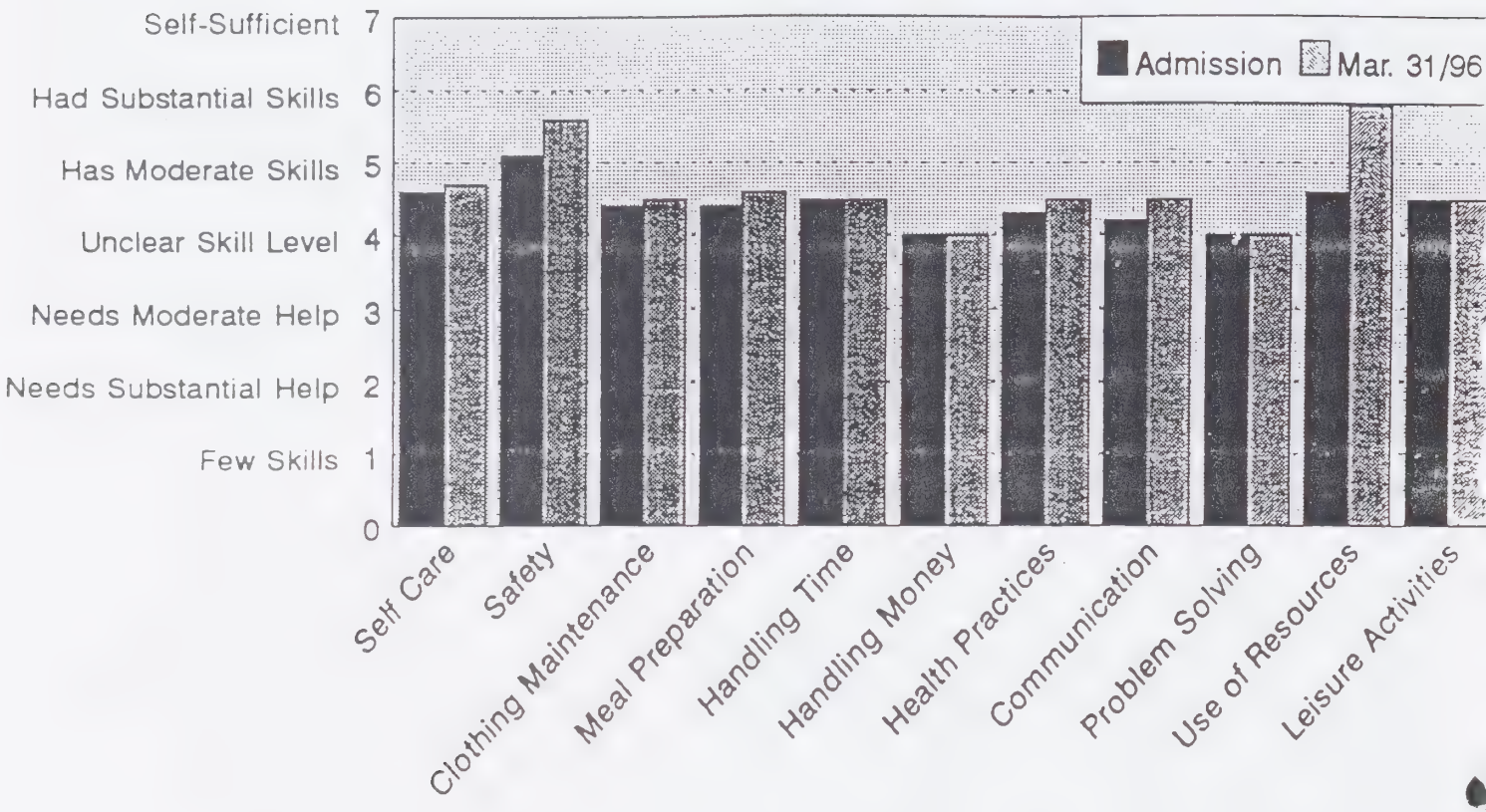


FIGURE 4: Comparison of Community Living Skills of Client in CMHPP Between Admission and March 31, 1996 or on Discharge



D) SOCIAL SUPPORTS

The consumer objective for social supports was evaluated utilizing the client outcome form. On admission, the social supports for clients were assessed in three areas which could include more than one area: a) no contacts beyond the nurse b) some other person to confide in and c) participates in social and recreational activities. It was found that 8% of the clients had no contacts beyond the nurse; 50% had some other person to confide in; 34% participated in social and recreational activities and 8% had b) and c). On March 31, 1996 there were 6% more clients participating in social recreational activities. The social supports for the clients in the Community Outreach Project were as follows: 7% of the clients had no contacts beyond the nurse; 72% had some other person to confide in and 21% participated in socialization activities. These results indicated that the clients in this project were less connected to social recreational activities than the other clients in the CMHPP; however, they were very connected to others such as "street network". The lack of connectedness to formal services was not surprising given their housing instability.

PROGRAM SERVICE OUTCOMES

CONSUMER OPINION OF THE PROGRAM OBJECTIVES AND ACTIVITIES

The Community Advisory Board requested a survey of the clients' opinion about the program objectives and activities (Appendix 2). Fifty seven percent of the total client caseload consented to complete the survey. Eighty two percent of the respondents agreed with the objective to establish a therapeutic relationship. Fifty nine percent agreed that the program needs to develop and/or improve clients' skills for living. Fifty percent of the clients responding supported the program's objectives to prevent hospitalization and to develop social supports through involvement with social, recreational and educational activities. Clients viewed the three key roles of the nurses as developing a helping relationship, providing health teaching and counselling. Eighty four percent reported that the best location to visit the nurses was in their home. The primary reasons given for an in-home meeting was their own territory, "privacy" and a sense of comfort. Being supportive through talking about their issues and providing information was the most helpful.

BRIDGE TO DISCHARGE PROJECT

In July 1995, the Community Mental Health Promotion Program in partnership with the Mental Health Rights Coalition and the Hamilton Psychiatric Hospital (HPH) completed the evaluation of the pilot project (Appendix 3). Clients received special services as they move from inpatient to community. This means that either i) a public health nurse begins to see the client on a regular basis, an average of six months prior to hospital discharge, or ii) a hospital nurse continues to see the client for as long as necessary after discharge. For each client, the hospital nurse and the public health nurse was working with the client to support a transfer of the client's trust to the nurse in the community. The client's discharge from hospital was not considered complete until a public health nurse had established a working relationship with the client as agreed to by the client and nurse. At the end of March 1996, there were twelve clients in the Bridge to Discharge project being seen jointly. An economical analysis comparing hospital and community costs was completed and found a savings of $496,862.55 to the taxpayer (Appendix 3).

JOINT CONSUMER AND PROVIDER HOUSING INITIATIVE WITH BRIDGE TO DISCHARGE PROJECT

At the end of March 1996, five clients lived in the independent housing initiative and eight clients lived in supervised housing such as second level lodging homes. Overall, through the therapeutic relationships and peer support, the program offered a smooth adjustment from institution to the clients' new home has been facilitated (Appendix 4).

COMMUNITY OUTREACH PROJECT

In April 1995, the CMHPP and the Hamilton Psychiatric Hospital initiated a one year pilot project for "hard to reach" women who experience homelessness and mental illness. The purpose of the project was to study the implementation of a community outreach strategy to people with serious mental illness who do not access traditional mental health services. The goal was to support these people to achieve optimal health and well-being and to provide case management services through primary health care approaches including health promotion, disease prevention, curative, rehabilitation and supportive services.

The admission criteria was people (primarily women) with temporary or chronic homelessness patterns, severe disability and psychotic symptoms. Linkages with community services such as Good Shepherd, Wesley Urban Centre, Housing Help Centre, Van Program with the Regional Public Health Department and other services existed.

Evaluation of the project consisted of qualitative and quantitative methods. Qualitative methods included clients' and community service providers' perceptions and the hospital and community nurses' perceptions of the project. Quantitative measures involved client demographics, nurse/client relationship assessments, community living skills inventory and housing patterns and tenure. The results of the hospital and community nurses' perceptions are completed (Appendix 5). Feedback from community service providers is underway.

This pilot project demonstrated that working relationships with people with mental illness who were known to be "hard to reach" can be established. Due to the disenfranchised nature and significant functional disability of this population, it was premature to determine the impact on their quality of life. The integration of community and hospital staff revealed a very promising partnership.

SEXUALITY HEALTH PROMOTION GROUP

During 1995/96, one sexuality health promotion group was held, in collaboration with Hamilton Program for Schizophrenia. The group consisted of up to nine people. Participants expressed satisfaction with the opportunity to choose topics, the mixed nature of the group and the availability of handouts. Interviews employing the Sexual Knowledge Interview Schedule (SKIS) was used to measure sexual knowledge and experience prior to attending the group and upon its completion. The total knowledge scale including feelings, body parts identification, body functions and general knowledge subscales showed a small improvement.

CONSULTATIONS WITH SLLH OPERATORS

In collaboration with the staff from the SLLH program, the CMHPP staff provided 197 consultations with SLLH operators. Consultations may include information on mental illness, community resources and symptom and behaviour management.

COMMUNITY LINKAGES

i) GARWOOD JONES LECTURESHIP

The CMHPP once again participated with other mental health services in planning the Garwood Jones Lecture series in October 1995.

ii) REGIONAL PSYCHIATRIC PROGRAM STEERING COMMITTEE (RPP)

RPP is a consortium of institutions and agencies who share a common mandate to provide psychiatric services to the population of Hamilton-Wentworth region. The mandate of the committee is to coordinate the planning, integration, and ongoing evaluation of child, adult and geriatric psychiatric services. Participation included involvement in the development of the Crisis Outreach and Support Team (COAST) and regional mental health planning activities.

iii) HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL MENTAL HEALTH REFORM STEERING COMMITTEE

The Community Mental Health Promotion Program program manager was selected to join the membership of this committee. The primary function of the steering committee is to facilitate the implementation of mental health care reform in Hamilton-Wentworth region.

EDUCATION

PROFESSIONAL DEVELOPMENT

The CMHPP staff participated in a number of continuing education activities depending on the nurses' learning needs. Educational sessions organized by the CMHPP for the nurses included: Probation and Aftercare services and the major mental illnesses. The nurses also had the opportunity to attend RPHD nursing rounds, Garwood Jones Lecture Series, Hamilton Program of Schizophrenia noon hour seminars, area hospital psychiatric rounds and workshops and conferences.

PRESENTATIONS

Forchuk, C., Schofield, R., Martin, M.L., Sircelj, M., Woodcox, V., Valledor, T., Jewell, J., Overby, B., Chan, L., Fraser, K. (1995). Bridging the Discharge Process: Qualitative Analysis of Staff Experiences Over Time. (poster presentation). Registered Nurses Association of Ontario Annual Meeting, Toronto, Ontario in April.

Forchuk, C., Schofield, R., Martin, M.L., Sircelj, M., Woodcox, V., Valledor, T., Jewell, J., Overby, B., Chan, L., Fraser, K. (1995). Bridging the Discharge Process: Quantitative Analysis of Quality of Life and Quality of Worklife. (poster presentation). Registered Nurses Association of Ontario Annual Meeting, Toronto, Ontario in April.

Schofield, R., Empowerment Education for Individuals with Mental Illness. Creating and Transforming Practice, Toronto, Ontario in June.

Forchuk, C., Schofield, R., Martin, M.L., Sircelj, M., Woodcox, V., Valledor, T., Jewell, J., Overby, B., Chan, L. (1995). Bridging Institution and Housing: A Joint Care Provider Initiative. International Association of Psychosocial Rehabilitation (IAPSR), Barrie, Ontario in September.

Forchuk, C., Schofield, R., Martin, M.L., Sircelj, M., Woodcox, V., Valledor, T., Jewell, J., Overby, B., Chan, L., Fraser, K. (1995). Bridging the Discharge Process. Mental Health Care: The Challenge of Change, An International conference sponsored by the Canadian Federation of Mental Health Nurses, Toronto, Ontario in October.

Valledor, T., Baccalon, A., Schofield, R., Forchuk, C., Martin, M.L., Sircelj, M., Woodcox, V., Jewell, J., Overby, B. (1995). Bridging Institution and Housing: A Joint Consumer Care Provider Initiative. (poster presentation). Mental Health Care: The Challenge of Change, An International conference sponsored by the Canadian Federation of Mental Health Nurses, Toronto, Ontario in October.

Forchuk, C., Schofield, R., Martin, M.L., Sircelj, M., Woodcox, V., Valledor, T., Jewell, J., Overby, B., Chan, L., Fraser, K. (1995). Bridging the Discharge Process: Qualitative Analysis of Staff Experiences Over Time. Annual Nursing Research Day, McMaster University, Hamilton, Ontario in October.

Forchuk, C., Schofield, R., Martin, M.L., Sircelj, M., Woodcox, V., Valledor, T., Jewell, J., Overby, B., Chan, L., Fraser, K. (1995). Bridging the Discharge Process: Quantitative Analysis of Quality of Life and Quality of Worklife. Annual Nursing Research Day, McMaster University, Hamilton, Ontario in October.

DEVELOPING MENTAL HEALTH NURSING SKILLS WITHIN THE HEALTH DEPARTMENT

The staff in the CMHPP provided consultation which includes education and clinical support to other public health nurses in the Nursing Division. In 1995/96, the staff provided about 142 consultations. Education consisted of information on mental illnesses, appropriate interventions and community mental health resources.

HEALTH SCIENCE STUDENTS

The CMHPP staff provided McMaster University Faculty of Health Science nursing students with clinical placements. In 1995/96, Mishi Ide, Lee Anne and Linda Veenhuis were preceptors for third and four year nursing students. Ruth Schofield provided clinical tutoring for five BScN students.

RESEARCH

BRIDGE TO DISCHARGE PROJECT

Evaluation was completed in June 1995 (Appendix 3). A proposal was submitted to Nation Health Research Development Program (NHRDP) funding to further study the transition of psychiatric clients from the hospital to the community in four settings.

The 1995/1996 Community Mental Health Promotion Program Annual Report is respectfully submitted.

Reviewed and Approved: Michael McDonagh
Chairperson Community Advisory Board

Thursday July 11 96
Date

Approved:
Chairperson of Health and Social Services Committee

July 9/96
Date

Prepared by: Ruth Schofield
Community Mental Health Promotion Program Manager

APPENDIX 1

CMHPP CLIENT OUTCOME CHECKLIST

nt Name: _____ Age: _____ CM / CT Sex: F / M
Admission Date: _____
Discharge Date: _____ Marital Status: Married / Single / Divorced / Separated / Widow(er)
Diagnosis: _____

Completion of Client Outcomes is to be done on Admission, Discharge/ or the end of March!!

1 = Few or no skills
2 = Needs substantial help or improvement
3 = Needs moderate help or improvement
4 = Skill level not clear or not observed**
*(** Use the rating '4' when the skill is not able to be shown, eg. meal preparation)*

5 = Has moderate skills
6 = Has substantial skills
7 = Self-sufficient, very adequate
C = Client perceived
N = Nurse perceived
N/A = Not applicable

1. **Relationship** (1) Orientation (2) Identification (3) Exploitation (4) Resolution									
2. **Self-Care** Such as bed making, personal hygiene, grooming									
Safety Such as proper use of cigarettes, matches, tools, writing materials, glasses									
4. **Clothing Maintenance** Such as doing laundry, ironing, sewing buttons, keeping clothes intact, using hangers									
5. **Meal Preparation** Such as cooking, shopping, serving, using microwave, doing dishes									
6. **Handling Time** Such as ability to keep appointments, return when due, participate in activities when scheduled, to work on time									
7. **Handling Money** Such as reasonable spending habits, some budgeting ability, keeping money safe									
8. **Health Practices** Such as handling medication, visiting doctor									
Communication Such as ability to ask for help when needed, make wishes known, express feeling in appropriate ways, engage in meaningful conversations									

10. **Problem Solving** Such as some independence, ability to seek help when needed, basic skills in decision making, ability to ask questions									
11. **Social Supports (can be more than one)** (1) no contacts beyond nurse (2) some person to confide in (3) participates in social recreational activities									
12. **Use of Resources** Such as telephone, transportation, cafeteria/restaurant, shopping and other community services									
13. **Leisure Activities** Such as some use of variety of activities such as newspapers, other reading, T.V., structured activities, hobbies, sewing, card playing									
14. **Employment** (1) Unemployment (2) Prevocational Program (Gateview) (3) Volunteer (4) Workshop (Amity, Marty Carl) (5) Group (IT, HARP) (6) Supported employment (7) Competitive									
15. **Living Situation** (1) Independent Supported (lives alone) (2) Assisted (lives with family, significant other) (3) Supervised (SLLH) (4) Hospital (5) Homeless (shelter, on street)									
16. **Discharge** (1) No follow-up needed (2) Follow-up refused (3) Admitted to hospital (4) Referred to _____ REASONS: (1) Suicide (2) Death (3) Other Reasons _____									
Date & Initial									

Evenson, R. & Boyd, M. (1993). The St. Louis Inventory of Community Living Skills. Psychosocial Rehabilitation Journal, 17(2), pp. 93-99.
(modified version of St. Louis Inventory of Community Living Skills, Oct 1995)

Date: _____ Signature: _____ Date: _____ Signature: _____ Date: _____ Signature: _____

APPENDIX 2

HAMILTON WENTWORTH DEPARTMENT OF PUBLIC HEALTH SERVICES
HEALTHY GROWTH AND DEVELOPMENT BRANCH
COMMUNITY MENTAL HEALTH PROMOTION PROGRAM

PROGRAM EVALUATION RESULTS

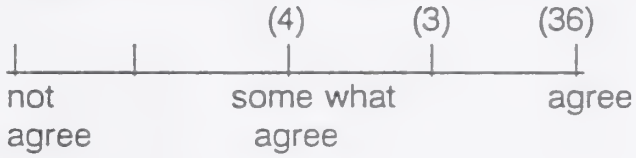
Complete = 44 Incomplete = 33 Total = 77

Reasons for Incompletes: Illness = 8
Refused = 9
Not Seen = 7
New in program = 4
Difficult to complete = 4
Comments only = 1

1 a) Clients in the past have identified that the program helps them in the following areas. Do you agree or not agree that this program helps you:

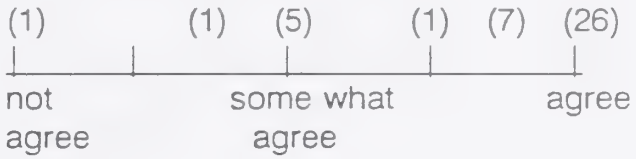
Note: Some clients evaluated themselves in these areas rather than the program.

- to have an open, comfortable and supportive relationship with the public health nurse agree



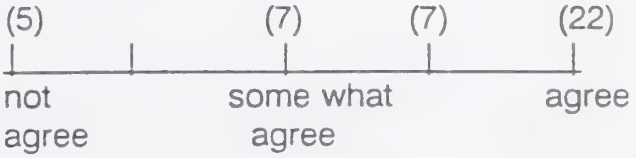
No Response (1)

- to develop and/or improve skills important for living



No Response (3)

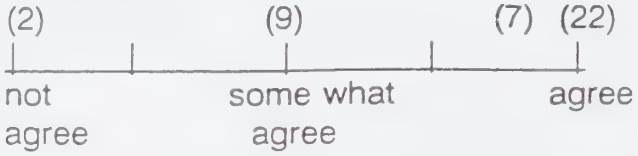
- to not get sick



No Response (1) Not Applicable (2)

Comments
- (not agree) → client has depression and arthritis
- (not agree) → Bipolar, pills do

- to do social, recreational and educational activities in the community with others as one chooses



No Response (2) Not Applicable (2)

Comments
- (not agree) → It's my fault, I don't want to do anything
- not in community

b) Would you suggest any other areas?
- no responses (40)
- education and health promotion (1)
- explanation of medication (1)
- free furniture and fixture (1)
- finance (1)

2) What do you think the role of the Public Health Nurse is? (Please check as many as you want).

a) develop helping relationship	38 *
b) health teaching	37
c) provide counselling	36
d) crisis intervention	32
e) advocate	29
f) link with other services	28
g) make referrals	28

* Responses are ranked from highest to lowest

3) What do you think is important in a helping relationship? (Please check as many as you want).

a) being able to talk to the nurse	40 *
b) trust	38
c) to be comfortable	36
d) feel supported	35
e) being available	31
f) feel safe to tell private thoughts and feelings	28
g) other comments	

No Response (2)

* Responses are ranked from highest to lowest

4a) Where is the best location for you to visit with the nurse? (Please check off one answer)

a) your place of living 37
b) coffee shop 1
c) her office ____
d) street ____
e) other(please explain) 1 (hospital smoke room)
1 (Amity)

- sometimes goes to Dr.'s appointment with me when I need help
- a & b (2)
- a & c (1)

No Response (3)

b) Why is the location important to you?

- because it's place I live in and for privacy (7)
- because their is a sense of comfort there (7)
- just cuz its easy (4)
- security of home (2)
- because I don't go out too much (2)
- makes me happy
- for my better feeling
- I can smoke here
- so I can go back to work quickly after lunch
- I feel more at home
- I'm near my bathroom because my back bothers me & I'm depressed
- hard for me to get around
- nosy listeners
- no transportation
- job
- no response (7)

5) How does the nurse help you? (Please check off as many as you want)

a) talk with me about my problems 39 *
b) help me when I'm not feeling mentally well 33
(please explain)

- just being there to talk to
- talking to nurse makes me feel better
- support and outlook, handling the problem
- when I'm depressed, talking to her helps me
- crisis intervention
- helps me understand and deal with depression and anxiety
- lets me know what is normal and not normal
- when I'm not feeling upset
- when I'm psychotic
- she gives me peace of mind
- support and reinforcement

- brainstorm sounding board
- talking
- when I feel that I've had enough, she trys to help me thru
- help on phone when I'm worried
- when I have depression my nurse cheers me up
- when I'm down you come, when you leave I feel better, more up
- focus on getting a job

No Responses (2)

c) help me feel good about myself 32
d) help me solve my problems 32
e) educate about my medications 28
f) help me learn about myself 28
g) help with issues around medications 27
h) inform me about social, vocational, recreational & education programs in the community 26
i) help me when I'm not feeling physically well 22
(please explain)
- mental illness has a lot to do with feeling unwell
- just by talking to me and understands
- explain UTI
- high BP and epilepsy
- provide reassurance and support
- encourage to go to Dr.
- with my medicine to go down
- bring me to Dr., help me with my pregnancy

j) help me get involved with these programs 21
k) assist me to obtain my choices 20
l) inform me about housing 15
m) other (please explain) - No Responses

* Responses are ranked from highest to lowest

6) What skills has the nurse helped you to learn? (check off as many as you want)

a) dealing with my family 25
b) making appointments eg. Dr. 23
c) coping with stress 23
d) dealing with my friends 19
e) filling out an application 14
f) dealing with my operator or staff 12
g) calling a community agency 10
h) learning how to budget 9
i) talking on the phone 4
j) learning how to shop 4
k) learning how to do laundry 2
l) learning how to cook 1

m) others (Please explain)
- help lighten my mood

No Responses (4)

* Responses are ranked from highest to lowest

7) What did you find most helpful about the services?
- get to speak to the nurse about my problems (14)
- information (2)
- talking about medication (2)
- visits (2)
- relationship (2)
- being able to give opinion and feedback
- help is always there
- taught me
- attentive listening
- helpful opinions
- understanding MI
- knowing that nurse is coming
- helps with jobs, training for jobs and education
- their attempt to make things right when they go wrong
- taking my BP
- talking to my psychiatrist
- communicating
- come when I ask and call me back when I cal
- different point of view
- aid and support in being a single parent
- helpful with family matter
- calm me down
- help me after my surgery and nervous breakdown
- for sick
- punctuality
- helpful
- grief counselling
- focus me on my goals
- good listener, I can get good suggestions how to solve my problems
- friendly personal feeling
- location very convenient
- she is there when I need to talk to someone qualified and knows me
- I'm thankful that this program I think has kept me out of the hospital
- keep me company

8) What did you find the least helpful about the services?

- going for coffee/chatting
- getting a hold of PHN
- nothing (2)
- I don't know
- not true psychotherapy available
- why can't the nurse drive me in their car
- not always timely
- not enough available help, services or programs

No Response (22)

9) Any suggestions to improve the services of the program.

- helpful
- nothing (6)
- your services are much needed (3)
- in emergency situation I'd like to be able to reach the nurse evenings and weekends (2)
- very good, excellent (2)
- communication access
- helpful
- provide transportation
- list of resources
- help fill dosettes
- "like more co-ordination around the things about me"
- extend and change hours, 24 hr help line, taxi voucher for joint Dr. appointments
- deeper understanding of addictions
- more time
- again

No Response (20)

OVERALL COMMENTS: - kind of long, lots of questions

Thank you for your time in completing these questions.

QUALITY AND COST-EFFECTIVE CARE: A NURSING SOLUTION

Preparation for Community Living: The Bridge to Discharge Project

THE ISSUE

Many individuals with a chronic mental illness are re-hospitalized because they are unable to adjust to community living.

A SOLUTION

Overlapping the services of psychiatric hospital nurses and public health nurses eases the clients' transition and adjustment to community living.

An Example

In a unique program[1] started by a long-term psychiatric hospital unit, a public health team and a consumer group, clients with a chronic mental illness are provided with overlapping inpatient and community services. This means that either the public health nurse begins to see the client on a regular basis, an average of six months prior to hospital discharge, or the hospital nurse continues to see the client for as long as necessary after discharge. The client's discharge from hospital is not considered complete until the public health nurse has established an ongoing relationship with the client as agreed to by the client and both nurses. Peer support is provided by the consumer group.

Results

Client related:

- clients are satisfied with the program (only two out of 11 clients required short-stay re-hospitalization)
- clients report that the program has improved the quality of their lives by providing a greater sense of autonomy and control, and contributing to a greater sense of self-worth and self-esteem.

Economic:
Over one year, the program saved $496,862.55.

Hospital (cost per patient day)	$331.49
Community (average cost per client day)	$81.50
Average savings per patient day	$249.99
Saving over one year (for 11 clients)[2]	**$496,862.55**

REFERENCES

1. Unpublished research by Forchuk, Cheryl, Schofield, Ruth, et al. (1995), *Bridging the discharge process: Quantitative analysis of quality of worklife and quality of life*, Hamilton Psychiatric Hospital.
2. Clients were discharged at different points throughout the year. Calculations include direct and indirect costs, and were based on the assumption that the 11 clients would have otherwise remained in the hospital (clients had been hospitalized for more than five years).

APPENDIX 4

THE JOINT CONSUMER AND PROVIDER HOUSING INITIATIVE EVALUATION

MEASURES

The measures include: teaching apartment questionnaire for clients and staff; boarding home questionnaire and an independent living questionnaire. These questionnaires were developed by the Bridge to Discharge Planning Group.

QUESTIONNAIRE COMPLETION

25 clients completed the teaching apartment client questionnaire (20 in-patients and 5 clients in the community). 22 staff completed the staff questionnaire. 12 clients completed the independent living and boarding home questionnaire.

TEACHING APARTMENT EVALUATION: CLIENT RESPONSES

Clients were asked seven open ended questions. All clients responded to the questionnaire. The seven questions asked were:

1) "What do you use the teaching apartment for?"
2) "Who do you prefer to see?"
3) "What do you like about the teaching apartment?"
4) "What do you not like about the teaching apartment?"
5) "Do you find the teaching apartment physically comfortable?" If no what suggestions do you have to make it more comfortable?
6) "Are the hours to use the apartment too little? enough? too much?"
7) "What suggestions do you have for improvement?"

Client Responses:

Teaching Apartment Uses: The clients reported that they primarily used the apartment for having parties, meeting with other people, participating in activities outside the hospital, talking to others, learning skills such as cleaning, and something to do.

CLIENT PREFERENCES IN STAFF

When asked if the clients preferred certain staff, the majority of hospital clients reported that they had no preference. However, the clients in the community reported that they preferred staff from the CMHPP.

FEATURES LIKED ABOUT THE APARTMENT

The clients in the community and in the hospital reported different features in order of significance. The community clients noted that being with other people was the most important feature to them followed by eating, learning new skills, and entertainment. The hospital clients reported that the break from the hospital was most important features followed by eating, entertainment, being with other people and learning new skills. The majority of clients found the apartment was physically comfortable for most activities.

FEATURES NOT LIKED ABOUT THE APARTMENT

The majority of clients gave no comments. Five clients commented that the apartment was too small especially when having parties.

HOURS OF USE

The majority of the clients (60%) reported that the hours of use were enough. However, 36% reported the hours of use were too little. One client did not respond.

SUGGESTIONS FOR IMPROVEMENT

Several clients made no suggestions. However, some clients suggested the following: redecorate the apartment, organize groups on specific topics, increase frequency of parties, and more work opportunities in the apartment (one client had a job placement in the apartment).

STAFF QUESTIONS

- "What do you use the teaching apartment for?"
- "What do you like about the teaching apartment?"
- "What do you not like about the apartment?"
- "What suggestions do you have for improvement?"

STAFF RESPONSES

Teaching Apartment Uses: The staff reported that they used the apartment for meeting with clients, resource to the drop-in, assisting clients with recreational activities, teaching life skills, education helping clients and paper work.

FEATURES LIKED

The central location, clean and well furnished, place for clients to go in the community for activities, and less institutional and a quiet environment.

FEATURES NOT LIKED

The small size of the apartments for especially parties, parking, and the isolated location in the building were identified by the staff as features not liked.

SUGGESTIONS

The staff gave a number of suggestions:

- improved physical features like cooking utensils, decorations, furniture and lighting
- install an eye hole in the door
- more opportunity for staff to learn skills necessary for the community
- public education of program
- increased hours of use

ADJUSTMENT TO THEIR NEW "HOME"

Clients were asked eight opened questions modified to either independent living or boarding home living. All twelve clients responded.

BOARDING HOME QUESTIONS: CLIENT RESPONSES

Clients living in boarding homes were asked the following questions:

- "Have you lived in a boarding home in the past?" If yes, how many boarding homes have you lived in in the past?"
- "How long have you lived in this boarding home?"
- "What was helpful when you moved into the boarding home?"
- "What was not helpful when you moved into the boarding home?"
- "What do you like about living in the boarding home?"
- "What do you not like about living in the boarding home?"
- "If you changed anything about living in a boarding home what would it be?"
- "What change, if any, to your life has it made to live in the boarding home?"

HISTORY OF LIVING IN A BOARDING HOME

There were seven clients who moved from the hospital into a boarding home. All but one client lived in a boarding home in the past. Clients reported living anywhere from 2 to 10 different boarding homes in the past. The reported current length of living in a boarding home was: under 6 months (2); 6 months to 1 year (3); and 1 year to 1½ years (2).

HELPFUL APPROACHES

Clients found that a number of approaches were helpful when they were moving into the boarding homes:

- "staff and other residents"
- "overnight stays before discharge"
- "money"
- "able to rest a lot better with help received"

UNHELPFUL APPROACHES

Most clients generally said that there was nothing that was not helpful to them in their move to the boarding home.

POSITIVE QUALITIES OF BOARDING HOMES

Clients identified a number of positive qualities about the boarding home:

- "own room - store stuff"
- "food, other people, the operator and staff, bed and bedroom"
- "downtown location"
- "able to go places and more freedom"
- "quiet atmosphere"

NEGATIVE QUALITIES OF BOARDING HOMES

Two clients commented that they had no negative qualities about the boarding home. The other clients made the following comments:

- "not able to use the phone, no freedom to drink, don't like their cleaning"
- "unable to use the kitchen"
- "dislike the landlord"
- "the heat "
- "no plug for fan"

WISHES ABOUT THE BOARDING HOME

Four clients commented they would not change anything about their boarding home. Suggestions for change were: "air conditioner"; "renovate the home" and "use the kitchen".

CHANGES TO ONE'S LIFE

Two clients reported that there was no change to their life and one client didn't know how to respond to the question. Four clients commented in the following way: "an improvement"; "like it"; "more variety of food, wanted own apartment" and "freedom".

INDEPENDENT LIVING: CLIENT RESPONSES

Clients living independently were asked the following questions:

- "Have you lived in an apartment in the past?" If yes, how long did you live in your apartment?"
- "How long have you lived in this apartment?"
- "What was helpful in setting up to live in your present apartment?"
- "What was not helpful in setting up to live in your apartment?"
- "What do you like about living in your apartment?"
- "What do you not like about living in your apartment?"
- "If you change anything about living in your apartment what would it be?"
- "What change, if any, to your life has it made to live in the apartment?"

HISTORY OF INDEPENDENT LIVING

Three of the five clients had lived in their own apartments in the past. For two clients this was their first experience of independent living. For those clients who had lived in their own apartments in the past, two reported they lived there for 1 ½ years and 2 years, the third client's length of independent living was three weeks. The current living arrangement reported was: under 6 months (1); 6-12 months (1); and 1-2 years (3).

HELPFUL TO MOVE

Several clients commented that the start up allowance, donations, staff and friends were very helpful. Assistance with transportation was noted twice.

NOT HELPFUL TO MOVE

The stigma associated with having a mental illness and coming from the hospital was initially felt by some of the clients when they moved into the apartment building. One client reported that they had no transportation for furniture and personal belongings. Two clients that they had no problems with their move.

POSITIVE QUALITIES ABOUT INDEPENDENT LIVING

Clients commented that they liked the foilowing about independent living:

- independence (3) "do what I want", "not being told what to do and when to do it"
- "more privacy than in a lodging home"
- "like being alone sometimes"
- "own place"
- "freedom to come and go when ever"
- " I live by myself"

NEGATIVE QUALITIES ABOUT INDEPENDENT LIVING

Loneliness was the most frequent negative aspect of independent living. One client didn't like having a bachelor apartment. Expense of the apartment was the third concern.

WISHES ABOUT INDEPENDENT LIVING

- air conditioning
- keeping the apartment neat and tidy
- more comfortable bed
- own bedroom

CHANGES TO ONE'S LIFE

- "more freedom" (2) and "dignity" (1)
- "more responsible; cooking for self; more time for watching T.V and reading"
- "independence, motivation has increased"

DISCUSSION

The project has been organized in such a way to promote continuous improvement and be responsive to clients' needs and wishes. The three partners meet once monthly to discuss the housing operation and strategic planning of the project. The data identified from the clients and staff has provided the opportunity to identify issues in need of improvement and act upon them.

CONCLUSION

The housing alternatives in the Bridge to Discharge Project offers an innovative and client-focused model to clients with severe mental illnesses. This model promotes partnerships between clients, the hospital and community care. We believe by maintaining supportive relationships, we have facilitated a smooth adjustment from institution to the client's new "home" thereby enabling them in their integration into the community.

APPENDIX 5

NURSES' EXPERIENCE

The nurses were asked four questions through an informal group discussion. Responses were recorded and the facilitator lead the focus group. The questions were as follows:

1) What has the integration of the PHNs and hospital nurse meant to you?
2) What was helpful in the process?
3) What was not helpful?
4) Any suggestions for the future? The subsequent themes were identified.

A) FRUSTRATION WITH AMBIGUITY

The public health and hospital nurses expressed an number of feelings about the integration. Feelings included uncertainty about the impact of the new role in the program and to them as nurses. With the new role, the focus of program and public health nursing was thought to be changing which resulted in feelings of ambivalence. For the hospital nurse the shift from a structured hospital work environment to a unstructured community work environment created the confusion. For some nurses the integration of the different sectors of nurses raised the reality of the changing sociopolitical climate for nursing, in particular public health nursing, and this realization created a sense of powerlessness and threat of being replaced by hospital nurses.

Nurses not only reflected on the impact to their nursing role but also on their perceptions of each other. During the initial period of the integration feelings of mistrust existed. Nurses described the experience in this manner "a foreigner was coming from the hospital", "paranoia", "suspicion" and being afraid to talk about public health clients.

The last theme of feelings emerged around the entry into public health nursing from a non public health nursing background. Nurses described a "testing" process for nurses without prior public health experience or with a BScN. This testing process resulted in feelings of stigmatization and a senses of being devalued.

B) BROADENING ONE'S PERSPECTIVE

Both groupings of nurses discussed that their perspective of nursing was "broadened". The hospital nurse felt that the generalist mandate of public health nursing enhanced her experience as a nurse. Public health nurses expressed that the mental health knowledge and skill of the hospital nurse helped them better identify and work with individuals with mental illness who were on the street.

C) CHANGING ROLES

i) Non Traditional Approach: the nurses involved with the project described the role of the nurse as needing to change in order to work with people with mental illness who are hard to reach as heard in these comments. "You have to understand the culture of the street family... be flexible... a lot of networking is informal... no form 14s and not medical in focus". The presence of being in the culture was felt to enable the nurses to engage in relationships often through client identified physical health concerns.

ii) Interface: Communication with nurses in other programs involved with the same population was recognized as crucial to prevent duplication and to problem solve. This thought of "fluid boundaries" between programs was identified as a reality and a need in the delivery of care to this population.

D) TEAM SUPPORT

The team functioning in the program has become key for support to the nurses in the new role. Support from the team came through providing ideas for a resource or just for debriefing from the stress and sense of hopelessness experienced. Team likewise provided a "sense of structure and predictability" for the hospital nurse and an opportunity to develop a broader base focus from other team members.

E) FUTURE DIRECTIONS

With the potential expansion of the project through a second HPH staff participating in the project, the team recommended that the hospital nurse be apart of the interviewing process. Through this recruitment process she could assist in the selection of the appropriate nurse and provide first hand experience to share with the potential candidates. The need for a BScN was not resolved and requires further discussion. Lastly, ongoing participation in the development of the project was supported by the team members.

During the first six months of the project, nurses found the integration of hospital and community nursing perspectives created both challenges and benefit to their practice and their views of nursing. Suggestions for future planning were made.

OPERATIONAL PLAN 1996/1997

COMMUNITY MENTAL HEALTH PROMOTION PROGRAM

MISSION STATEMENT:

The Hamilton-Wentworth Regional Public Health Department (RPHD), strives for a healthier community through excellence in health promotion, health protection and disease prevention programs and services; the purpose being to achieve optimal health for the community.

GOALS:

- To promote the achievement of optimal health and well-being among adults with severe mental illness living in the community.
- To design the Community Mental Health Promotion Program (CMHPP) to meet the individualized needs of adults with severe mental illness.
- To design the CMHPP to reflect social and environmental determinant of health.
- To provide primary health care including health promotion, disease prevention, curative, rehabilitative and supportive services.

CONSUMER OBJECTIVES:

1.0 To have an open, comfortable and supportive relationship with a nurse.

2.0 To develop and/or improve skills important for living.

3.0 To stay functional in the community.

4.0 To do social, recreational and educational activities in the community with others as one chooses.

PROGRAM OBJECTIVES:

1.0 To provide case management and counselling/treatment services for adults with severe mental illness and those at risk for mental illness. That is, gender, race and culturally sensitive services which are responsive to the special needs of vulnerable adults.

2.0 To facilitate the development of a supportive environment for adults with severe mental illness living in the community including second level lodging homes (SLLH).

3.0 To collaborate and coordinate the services of the Community Mental Health Promotion Program with other community agencies.

4.0 To advocate for public policy for adults living with severe mental illness in the community, e.g., community policy to assist integration into the community from the psychiatric hospital and to help people help themselves.

5.0 To create, identify and develop opportunities for consumers and professionals growth and development.

6.0 To act as a resource to the Public Health Department staff regarding mental health issues.

7.0 To provide learning opportunities for Health Science students.

8.0 To continue to utilize and develop in-house research in the Community Mental Health Promotion Program and to apply the research findings in program planning, implementation and evaluation.

9.0 To maintain and share data to develop mental health promotion programs that reflect the needs of adults with severe mental illness living in the community.

CONSUM BJECTIVES

OBJECTIVES:

1.0 To have an open, comfortable and supportive relationship with a nurse.

2.0 To develop and/or improve skills important for living.

3.0 To stay functional in the community

4.0 To do social, recreational and educational activities with others as one chooses.

PROCESS	TARGET POPULATION	PROGRESS INDICATOR	CRITERIA FOR OUTCOME
1.0 • Through regular mutual agreeable meetings, client goals are identified		• document changes in relationship on Client Outcome Form • Record review annually	• Progress in development of therapeutic relationship • Achievement of client goals
2.0 • Client identifies with the nurse, skills important for living to be developed and a plan of action to enhance or maintain skills		• Skills identified • Plan of action documented • Client Outcome Form completed on admission and end of fiscal year • Record reviews yearly	• Skills important for living • 50% of clients demonstrate improvement within the first 18 months of community living skills • Client satisfaction
3.0 • Client identifies with the nurse, pattern of hospitalization, health concerns and problem solve together to address health concerns to prevent crisis as possible and to stay functional in the community		• # of hospitalization and pattern recorded and analysized on admission and end of fiscal year • Record review documenting intervention	• Increased interval between hospitalization after 18 months of being in program • decreased length of hospitalization
4.0 • Client identifies need to become socially involved and jointly plans with nurses social activities to support and implement plan of action developed		• Activities identified by client • Plan of action documented • Client Outcome Form completed on admission and end of fiscal year • Record review	• After 18 months, 50% demonstrate improvement in social support and other community living skills

PROGRAM OBJECTIVES

OBJECTIVE: 1.0 To provide case management and counselling/treatment services for adults with severe mental illness and those at risk for severe mental illness. That is, gender, race and culturally sensitive services which are responsive to the special needs of vulnerable adults.

PROCESS	TARGET POPULATION	PROGRESS INDICATOR	CRITERIA FOR OUTCOME
1.1 • The nurse engages in a short-term counselling/treatment relationship in order to help people help themselves.	• adults at risk for mental illness n = 18	• record reviews (see consumer objectives) and quarterly stats will demonstrate documentation of client needs, consumer-driven interventions and achievement of client goals	• 6 clients per nurse (3) • progress towards client goals achieved during a two year period (see consumer objectives) • shift to case management in collaboration with the client occurs if needed after two years
1.2 • The nurse engages in a long-term relationship in order to help people help themselves.	• adults with severe mental illness n = 63	• record reviews (see consumer objectives) and quarterly stats will demonstrate documentation of client needs, consumer-driven interventions and achievement of client goals	• 21 clients per nurse (3) with no more than 13 discharges per year • progress towards client goals achievement
1.3 • Nurses engage in a significant relationship with people with severe mental illness and who are homeless.	• adults with severe mental illness & homelessness n = 15-20	• number of contacts • number of referrals • number of linkages with other services • quantitative and qualitative measures • see program objective 1.2	• up to 20 clients • after 18 months, clients demonstrate increased living tenure, improved community living skills
1.4 • Clients, CMHPP PHNs/Manager jointly continue to implement in collaboration with Hamilton Psychiatric Hospital staff for integration of hospital staff in community and to maintain community based skills and for provision case management services.	• hospital staff • adults with severe mental illness	• number of joint meetings • number of HPH staff participating • see program objective 1.2	• long term hospitalized consumers moved into the community • progress towards hospital staff with community focus skills
1.5 • Implement a collaborative and supportive housing project with consumers and service providers.	• adults with severe mental illness	• number of identified clients • number and type of links • see consumer objectives	• up to 10 clients living in independent living situations • multidisciplinary links established where possible • see consumer objectives
1.6 • Manager and psychiatric consultants will provide consultation to the CMHPP nurses.	• CMHPP PHNs • RPHD PHNs	• number of consultations • number of psychiatric consultations	• PHNs report satisfaction with manager through Manager Evaluation and through psychiatric consultation (annual evaluation)

... environment for adults with severe mental illness living in the community including second level lodging homes (SLLH).

PROCESS	TARGET POPULATION	PROGRESS INDICATOR	CRITERIA FOR OUTCOME
2.1 • Provide assessment/consultations to lodging home operators and other care givers in the community upon request.	• operators and service providers	• number of consultations/assessments	• annual utilization review of consultation service

OBJECTIVE: 3.0 To collaborate and coordinate the services of the Community Mental Health Promotion Program with other community agencies.

PROCESS	TARGET POPULATION	PROGRESS INDICATOR	CRITERIA FOR OUTCOME
3.1 • PHNs/Manager, the Community Advisory Board and the community jointly plan the direction of the CMHPP.	• adults with severe mental illness	• number of meetings • number of issues raised • minutes reflecting groups' actions	• 50 percent consumer participation • Boards' advices influences program direction
3.2 • Coordination and collaboration (refer to program objective 4.1).			
3.3 • Offer and evaluate a sexuality program for the psychiatrically disabled.	• adults with severe mental illness	• SKIS, client satisfaction pre-test to post-test completed with all participants • number of group sessions and attendance • anecdotal accounts	• up to two groups per year, 10 to 12 consumers or based on community need • 50 percent of clients demonstrate an increase in SKIS • client satisfaction

OBJECTIVE: 4.0 To advocate for public policy with adults living with severe mental illness in the community, e.g., community policy to assist integration into the community from the psychiatric hospital and to help people help themselves consistent with mental health care reform.

PROCESS	TARGET POPULATION	PROGRESS INDICATOR	CRITERIA FOR OUTCOME
4.1 • PHNs/Manager participate in meetings with other mental health services to plan the coordination, collaboration and integration of Mental Health services.	• Adults with serious mental illness	• number of coordinated events • submission of reports as required • minutes	• increase linking with key stakeholders • healthy public policy changes

OBJECTIVE: 5.0 To create, identify and develop opportunities for professional growth and development.

PROCESS	TARGET POPULATION	PROGRESS INDICATOR	CRITERIA FOR OUTCOME
5.1 • PHNs learning needs are identified and a plan of action is developed.	• CMHPP PHN	• learning needs identified • number of scheduled inservice times once per month	• all staff will participate in learning/development activities. Learning plan will be implemented per staff. Staff will use their contract allotted PD days.
5.2 • PHNs will continue to implement a consumer-driven approach in case management services consistent with mental health reform.	• CMHPP PHNs	• utilize consumer driven intervention • record review	• 100 percent of clients receiving consumer driven approach
5.3 • PHNs/Manager participate in meetings with other case management services in Ontario to promote professional training and development in case management	• providers	• planning education opportunities and resource development	• 1-2 provincial workshops per year • 1-2 learning packages completed

OBJECTIVE: 6.0 To act as a resource to the Public Health Department staff and Community Agencies regarding mental health issues.

PROCESS	TARGET POPULATION	PROGRESS INDICATOR	CRITERIA FOR OUTCOME
6.1 • CMHPP manager/PHNs will accept and process mental health consultations from nursing staff, and make home assessments on request. Consultation with community partners will be accepted based on need.	• nursing staff and community partners	• number of consultations	• all requests will be responded to and documented by a member of the CMHPP (200/annum)

OBJECTIVE: 7.0 To provide learning opportunities for Health Science students.

PROCESS	TARGET POPULATION	PROGRESS INDICATOR	CRITERIA FOR OUTCOME
7.1 • CMHPP team members will continue to assess and to accommodate requests for educational placements of students within the CMHPP.	• Health Science students	• requests for educational placements will be reviewed and accepted accordingly • student evaluation of the clinical setting	• a maximum of 1-2 students per year will be placed with the CMHPP during 1994

OBJECTIVE: 8.0 To continue to utilize and develop research in the Community Mental Health Promotion Program and to apply the research findings in program planning, implementation and evaluation.

PROCESS	TARGET POPULATION	PROGRESS INDICATOR	CRITERIA FOR OUTCOME
8.1 • Evaluate the Community Outreach Project (see program objective 1.3)	• Hospital staff • Adults with severe mental illness and homelessness	• utilization of qualitative and quantitative sources to collect data from consumers, staff and community partners • completion of Client Outcome Checklist (see consumer objectives and 1.3)	• Clients demonstrate increased housing stability and increased quality of life • staff demonstrate integration • community partner satisfaction
8.2 • Evaluating "Bridging the Discharge Process" pilot project (see program objectives 1.4)	• hospital staff • adults with severe mental illness	• submit proposal to NHRDP for funding a provincial study	• quality of life • quality of work life • economic analysis • therapeutic relationships

... to collect and utilize data to develop mental health promotion programs that reflect the needs of adults with severe mental illness living in the community.

PROGRAM REQUIREMENT:

PROCESS	TARGET POPULATION	PROGRESS INDICATOR	TARGET OUTCOME
9.1 • CMHPP manager and the Community Advisory Board will complete operational plan and annual reports for purposes of sharing information about the CMHPP with the MOH, with other RPHD programs, Regional Psychiatric Program and District Health Council.	• Ministry of Health, Hamilton-Wentworth RPHD, District Health Council, Advisory Board	• annual report reflects activities and evaluation of the program.	• published 1995/1996 Annual Report • review and evaluation of CMHPP
9.2 • CMHPP manager will complete quarterly, semi-annual, and annual budget reports and other reports as required by the MOH. Review impact of deficit (and funding).	• Ministry of Health, Hamilton-Wentworth RPHD	• budget actual, approved and forecast for MOH 1995/1996 fiscal year	• meet budget requirements cost effectively

Program Type: 10 - COORDINATION- CASE MANAGMENT	Program Code 4048	Page 1
Location: HAMILTON	Program Name: COMMUNITYMENTALHEALTHPROMOTION PROGRAM	

Item	LINE	Reference	1995-96 Estimated Actual $	1995-96 Annualized Budget $	1996-97 Proposed Budget $
OPERATING EXPENSES			(1)	(2)	(3)
Salaries Direct	1	Page 2, L8	193,105	194,913	194,913
Salaries Other	2	Page 2, L16	15,915	16,000	16,000
Employee benefits	3	Page 3, L14	35,954	34,100	34,100
TOTALSALARIES & BENEFITS	4	Lines 1, 2, & 3	244,974	245,013	245,013
SESSIONAL FEES	5	Page 3, L15	4,665	5,598	5,598
TOTALSUPPLIES, RENT & UTILITIES	6	Page 4, L14	33,181	33,219	27,659
NET OPERATING EXPENSES	7	Lines 4, 5 & 6	282,820	283,830	278,270
Add: Approved One-time Grant	8				XXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9		XXXXXXXXXXXXX	XXXXXXXXXXXXX	XXXXXXXXXXX
TOTALOPERATING & ONE-TIME EXPENSE	10	Lines (7+8-9-12)	282,820	283,830	278,270

TOTALNO. OF FTE'S	11	Page 2, L17	4.25	4.25	4.25

Program Type: 10 - COORDINATION- CASE MANAGEMENT	Program Code 4048	Page 2
Location: HAMILTON	Program Name: COMMUNITYMENTALHEALTHPROMOTION PROGRAM	

Salary / Staff Classification	LINE	1995-96 Estimated Actual $	1995-96 Annualized Budget $	1996-97 Proposed Budget $	FTEs 1995-96 Estimated Actual	FTEs 1995-96 Annualized Budget	FTEs 1996-97 Proposed Budget
SALARIES							
DIRECT STAFF		(1)	(2)	(3)	(4)	(5)	(6)
Program Manager/Director	1	41,323	42,060	42,060	.75	.75	.75
Assistant Manager/Director	2						
Program Supervisors, Team Leaders	3						
Program Workers (counsellors, therapists, case managers, etc.)	4	151,782	152,853	152,853	3.0	3.0	3.0
Other: (specify)	5						
	6						
Relief Staff	7						
Total Salaries: Direct Staff (To page 1, Line 1)	8	193,105	194,913	194,913	3.75	3.75	3.75
OTHER STAFF		(1)	(2)	(3)	(4)	(5)	(6)
Administrative Assistant/Office Manager	9						
Clerical	10	15,915	16,000	16,000	.5	.5	.5
Accountant/Bookkeeper	11						
Maintenance/Janitor	12						
Other: (specify)	13						
	14						
Relief Staff (Specify)	15						
Total Salaries: Other Staff (To Page 1, Line 2)	16	15,915	16,000	16,000	.5	.5	.5
Total Salaries: Direct & Other Staff	17	209,020	210,913	210,913	4.25	4.25	4.25

	Program Type: 10 - COORDINATION- CASE MANAGEMENT	Program Code 4048	Page 3
Location: HAMILTON	Program Name: COMMUNITYMENTALHEALTHPROMOTION PROGRAM		

EMPLOYEE BENEFITS

	LINE	1995-96 Estimated Actual $	1995-96 Annualized Budget $	1996-97 Proposed Budget $
Pension Plan	1	11,986	11,368	11,368
Canada Pension Plan	2	4,795	4,546	4,546
Worker's Compensation	3			
Group Insurance	4	2,976	2,823	2,823
Employee Health Tax	5	3,894	3,693	3,693
Dental Plan	6	2,995	2,841	2,841
U.I.C.	7	5,594	5,306	5,306
Disability Plan	8	3,714	3,523	3,523
Extended Health Care	9			
Vision Care	10			
Other: (please identify)	11			
	12			
Total Benefits: (To Page 1, Line 3)	14	35,954	34,100	34,100

SESSIONAL FEES

	LINE	1995-96 Estimated Actual	1995-96 Annualized Budget	1996-97 Proposed Budget
Total Sessional Fees	15	4,665	5,598	5,598
No. of Sessions	16	15	18	18

OF HEALTH — HEALTHBRANCH (CMHB)

SUPPLIES, OTHER EXPENSES, RENT & UTILITIES

	Program Type: 10 - COORDINATION- CASE MANAGEMENT	Program Code 4048	Page 4
Location: HAMILTON	Program Name: COMMUNITYMENTALHEALTHPROMOTION PROGRAM		

Item	LINE	1995-96 Estimated Actual	1995-96 Annualized Budget	1996-97 Proposed Budget
SUPPLIES & OTHER EXPENSES		(1)	(2)	(3)
Travel Expenses - staff (inc. education and conferences)	1	5,522	4,732	4,732
Food	2			
Accounting & Bookkeeping	3	6,210	6,210	6,210
Audit Fees	4			
Professional Fees (specify)	5	0	154	100
Staff education expenses	6	1,802	2,112	1,800
Computer maintenance and supplies	7			
Telephone (Incl. Long Distance)	8	2,750	2,755	1,800
Postage, Stationery, Office Supplies	9	3,162	3,025	3,000
Other Expenses	10	4,135	4,638	4,017
Rent	11	9,600	9,593	6,000
Property Taxes	12			
Utilities	13			
TOTALSUPPLIES, RENT & UTILITIES	14	33,181	33,219	27,659

Approved by: _____ Date: July 10, 1996
(Chair/Vice-Chair/Treasurer)

Title: Chair, HPSS
(of signatory)

RS jp

MINISTRY OF HEALTH
COMMUNITY MENTAL HEALTH
PRELIMINARY OPERATING BASE ALLOCATION
FOR 1996/97 AND 1997/98 FISCAL YEARS

FACILITY NAME: Community Mental Health Promotion Program

LOCATION: HAMILTON

PROGRAM #: 4048

DBS#: 86818

1995/96 Operating Base Allocation	$	283,830
Administrative Efficiency Reduction of 2%	$	5,560
1996/97 Preliminary Operating Base Allocation	$	278,270
Administrative Efficiency Reduction of 3%	$	8,340
1997/98 Preliminary Operating Base Allocation	$	269,930

NOTE: 2% for 1996/97 and 3% for 1997/98 reduction is on 1995/96 adjusted operating base allocation, which excludes 1995/96 sessional fees allocation.

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